Euthanasia

Euthanasia, efficiency, and the historical distinction between killing a patient and allowing a patient to die

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Voluntary active euthanasia and physician assisted suicide should not be legalised because too much that is important about living and dying will be lost

In the first of this two part series, I unpack the historical philosophical distinction between killing and allowing a patient to die in order to clear up the confusion that exists. Historically speaking the two kinds of actions are morally distinct because of older notions of causality and human agency. We no longer understand that distinction primarily because we have shifted our notions of causality from a traditional formulation to a modern formulation of causality and thus of moral assessment that focuses on the effects of an action. In this essay, I prepare the ground for a companion essay by showing that the traditional formulation allows us to maintain notions of meaning and purpose to human living and dying that are precluded in the efficiency paradigm of modernity. Taken together with the companion essay, I am claiming that voluntary active euthanasia (VAE) and physician assisted suicide (PAS) should not be legalised because too much that is important about dying and living will be lost.

TWO LIES

It would be naïve to think that euthanasia, in either the VAE sense, or in the more passive sense of PAS, does not happen. It would even be naïve to think that it does not occur in a non-voluntary form. It would be equally naïve, however, to think it could be controlled through governmental regulation. The real question with regard to PAS/VAE, put so eloquently by Martha Minow, is which lie do you countenance: the lie that euthanasia does not already happen, or the lie that it can be controlled without having repercussions well beyond the limits of procedural mastery?[1] With this two part paper series, I will argue that the former of the two lies is the lie that we should countenance.

Before I can make the case that it is better to countenance the former lie, however, I shall have to first settle on definitions and second to do some historical philosophical work, and this is the purpose of this first essay. I shall lay out the historical philosophical roots of the distinction between killing a patient and allowing a patient to die. As there is so much confusion about language with regard to euthanasia—which, in the original Greek, simply means good death—I shall first set out a few definitions. I shall use VAE to mean the active taking of the life of a person who has requested assistance in their suicide. By active assistance here, I mean the actual administering of a substance such as sedatives or potassium chloride. I will use PAS to mean the more passive action of writing a prescription that the patient can use to take his own life. In both instances of VAE and PAS, the physician will be certain that the patient wishes to have his life ended and that the decision is an autonomous decision. Another form of euthanasia is involuntary euthanasia. Both VAE and PAS are voluntary. It is possible for active euthanasia to be involuntary. It is possible for PAS to be involuntary, if the physician prescribes it to an unknowing patient. At this point in time, all forms of assistance in dying are illegal, but we tend to find involuntary euthanasia to be more troubling ethically speaking. There is another important action taken by the physician in the care of the dying; that action is the action of allowing the patient to die.

Traditionally speaking, all versions of suicide, that is to say all versions of euthanasia—save allowing a patient to die—were considered immoral actions, and because immoral they would have been illegal. Of late, many have argued that there is a distinction between VAE and PAS. Others have argued that an action normally allowed under the rule of double effect could be a form of VAE. Still others have argued that there is no distinction between allowing a patient to die and taking the life of the patient with either VAE or PAS. Yet, the older morality understood all the actions except the action of allowing a patient to die to be morally suspect and in fact a form of murder. The older morality with regard to euthanasia makes no sense to us, today. Can it be, however, that our predecessors were just irrational and unsophisticated thinkers? Or could it be that the distinction between killing and allowing to die cohered in an older moral framework? I shall argue the latter. PAS and VAE were morally the same, and both PAS and VAE were morally distinct from allowing a patient to die because these actions were understood within an older version of causality. Thus, in part, I am making an historical point in this essay.

VAE and PAS were morally the same, and both were morally distinct from allowing a patient to die. This distinction cohered primarily within an older understanding of causality, in which the series of material effects were always tied up with formal and final causality—that is, tied up with a metaphysics of purpose. I shall show that in embracing a metaphysics of efficiency, this older distinction no longer coheres for us. The moral conclusions of this older metaphysics give rise to more spiritual claims with regard to human meaning. I will show how in embracing the metaphysics of efficiency—that is to say in embracing the final effect in the series of causes and effects, namely death—one precludes the possibility of healing in that robust sense of human purpose, meaning, and experience. This essay will help to delineate the framing questions that should be acknowledged when thinking of legalising either PAS and/or VAE.

ON SHIFTING CAUSES

Before getting to the crux of the argument, I want to briefly explicate certain notions of causality that existed prior to the Enlightenment. Doing so will allow me to do two things for the purposes of this paper: 1) It will allow me to show why we no longer understand the traditional formulation of the distinction between killing and allowing to die, and 2) it will also allow me to show the importance of broader and more ancient notions of causality in our notions of healing.

Before the scientific revolution, the predominant Aristotelian worldview assumed four types of causality: formal, material, efficient, and final.[2] Formal causality is tied up with the Platonic Idea, or *eidos*. The *eidos*, also called the *form*, is instantiated within the substance of a thing or action. The formal cause of this paper, for example, is the idea that I wish to express. The material

cause is the matter that takes on the form. The ink on the paper would be the material cause in that it is the material that gives physical substance to the ideas. The efficient cause refers to the instrumental bringing into effect of the ideas. Not only then would the computer—the instrument through which I bring these words into being in this paper—be an efficient cause, but so would the ink which becomes the instrument of communication. Here the efficient and material causes coincide. The final cause is the *telos*, the end or purpose for which something is done. It is the very reason for which I write this essay: to bring my ideas into being for you the reader.

As part of the revolution in natural philosophy of the 16th and 17th centuries, physics turned away from the Aristotelian paradigm of causality.[3] Everyone from Bacon to Descartes attempted to remove teleology from science, dropping the formal and final causes from their scientific explanations.[4 5] They did so because formal causality derived from speculation about Platonic ''forms'', which were not discernible in experience, nor necessary for explanation. These were too speculative. Moreover, final causality was tied up with human understandings of the end or *telos* of the universe, and led to biased observations. The resulting shift in modern physics resulted in a kind of materialism, where matter was not understood so much as a cause, but as the basic building blocks from which scientists could create their theories; these theories could then be directed into practical application in order to mould and manipulate the world for efficient control.

Thus, the only remaining type of causality for the natural philosophers of the Enlightenment, and for us their heirs, is efficient causality—cause and effect within the material world. The world becomes something that is merely manipulated for human material purposes and human control, if you are inclined to think of humans as free agents who can act in the world. Still, there is another read on human agency under this scheme and that is that humans are also determined bits of the universe, and thus human action is itself part of the cause-effect mechanism. On this version, the world is a machine, a kind of clock that is wound up and runs itself out according to various laws. With Enlightenment philosophy, humankind with all of her ''purposes, feelings, and secondary qualities was shoved apart as an unimportant spectator and semi-real effect of the great mathematical drama'' (Burtt,[3] p 104).

For our purposes, I want to draw two conclusions from this account—one moral and the other spiritual. The traditional understanding of causality in the realm of human activity centres round formal and final causality. In the realm of morality, moral evil is that evil that comes about because of the action of the human will, that is to say because of final and formal human causes, better known to us as intention. Human death in the traditional formulation is not a moral evil, but an ontic, or physical, or premoral evil, even though it is not the highest or worst evil.[6] Thus, the death of a person can be ontically evil without being morally evil; but it is morally evil if the human acts intentionally—formal and final causality—to bring it about.[6] I will make this point more clearly later.

The other point to which I should like to draw our attention is that every human action, in the traditional, pre-enlightenment formulation, carries with it consequences and meanings beyond the mere physical effects that it brings about. Thus, in the premodern conception, every human action has a spiritual dimension. On this scheme, every human experience and every human action transcends the conditions of its own possibility. In the birth of a child, one experiences joy beyond the physical arrival of the child, and in death, one experiences the agony of the loss of what is no longer present. One's actions also carry with them more than the material effect. Thus, in a traditional formulation, one sees formal and final causes at work in the efficient and material causes. In the Christian formulation of this metaphysics, one can experience God in the mundane experiences of life, in one's work, in face of the other, and even in one's own dying. Once a robust formal and final causality are removed as possibly contributing to the understanding of human action and human thriving, one is left to evaluate human action in terms of its consequences, in terms of the utility that the action has. Human purpose and meaning are replaced as secondary to the efficient and material aspects of human activity, both moral and spiritual.

TRADITIONAL FORMULATION OF ACTS OF COMMISSION AND ACTS OF OMISSION

I would now like to turn to the moral dimension of the shift in causality. Thomas Aquinas believed that human action consists, for lack of a better way to put it, of two parts. The first part, the intention, vivifies the second, physical part. The intention and the efficient and material means, taken together, combine to make a human action. To use the language of causality just explicated, with intention one sees the formal cause of the action, but also the *telos* or final cause—that for the sake of which the action is taken. Thus, the formal and final causes coincide in the intention of the agent. Intention is what makes human actions alive and real within the world.[7] The second part of the action includes the material utilised to effect the change in the state of affairs of the world. Thus the second part of an action contains both material and efficient causes.

Based upon this kind of reasoning, it was commonly accepted in the philosophical tradition that actively killing an innocent person is the same as choosing not to intervene to save that person, because the intention of the action—the formal and final cause of the action—requires an act of the human will. Thus the death of the person—an ontic evil—becomes a moral evil because it results from human intention. Drowning a child in a bath in order to collect the insurance is not different from standing beside the bath and allowing the child to slip beneath the water and to drown in order to collect the insurance—the final cause is the same.[8] The person is equally morally culpable for either decision, because the intention was the same—to collect the insurance through the means of the death of the child. In the first case, one acts to kill and in the other, one acts by choosing not to act—both actions are done in order that the child die. The former has traditionally been considered an act of commission, the latter as an act of omission. Acts of omission are not morally different from acts of commission, for both are direct results of human intention. Both are direct actions of the human will.

Thus, in the traditional formulation, which relates to how one determines culpability even in contemporary law, there can be no difference in participating actively to cause the death of a patient (acting to drown the child) and participating passively to cause the death of the patient (acting by not saving the child). The intention is the same in both instances.

Some commentators, such as Quill[9] and Brody,[10] question the importance of intention in human action, stating that intentions are often ambiguous. For instance, a physician might write a prescription for an amount of medication that would be effective in taking the life of a patient. If the patient carried it out this would be PAS. Yet by his action of writing the prescriptions, Quill and/or Brody might claim that the doctor may intend to re-empower a patient. It has been claimed patients often do not utilise the medications to

take their lives but only want to have the power to take their own lives even if they never follow through. In other words, the physician might intend to re-empower the patient by writing the script for the medication. As Sulmasy and Pellegrino point out, however, one's intentions cannot be to alleviate the patient's anxiety through giving her a lethal cocktail to kill herself. That would be like treating the anxiety of a patient that is angry enough to kill his boss, by giving him the means to kill the boss, thinking that this action will calm him down.[11]

While it may be difficult in the messiness of the world to determine one's intentions, it remains true that the law very much considers the intention of the actor to be part of determining legal culpability. Thus, a simple test might serve as a guide in examining one's intentions. Alan Donagan proposes that we ask ourselves if ''by some fluke or miracle, the action does not have the effect you foresee…whether you then consider your plan carried out and your purpose accomplished''.[12] If a physician writes a prescription for a cocktail that will kill the patient, and the patient takes the medicines in order to kill herself and the patient fails, would the physician's intentions have been met? If he answers no, then he intended her death.

THE TRADITIONAL DISTINCTION BETWEEN KILLING AND ALLOWING A PATIENT TO DIE

In the traditional formulation, there is thus no distinction between acts of commission and acts of omission, but there is a morally important distinction that remains helpful for the care of the dying; that distinction is between directly and indirectly causing death. Today, directly causing death is often seen as parallel with acts of commission; indirectly causing death is commonly confused with acts of omission.[9 10 13 14] But nothing could be further from the case in the older formulation. Acts of commission and acts of omission are both forms of directly causing death for both entail the direct action of the will. Allowing a patient to die of natural causes is neither an act of commission, nor an act of omission, however, for in allowing the disease to take the patient's life, one does not necessarily intend the death of the patient; that is to say, one does not formally or finally cause the death. The death occurs only as the indirect result of an action. The disease—material and efficient causes—results in the death.

Thus, on the one hand, both acts of commission and acts of omission result from a direct action of the will—intention—and thus the actor is morally responsible for the action in the older formulation. On the other hand, in allowing the disease to cause death the actor has not formally or finally caused the death—that is, his intention has not made the action one for which she is morally responsible. The difference between direct and indirect is this: 1) in both acts of commission and acts of omission the intention is the same, the death of the patient. Thus, VAE and PAS both result from direct actions of the will; 2) VAE/PAS are distinct from allowing a patient to die because the death results directly from the disease and only indirectly from the choice not to act. The intention in this choice might be to preserve dignity, to make the patient comfortable. With both PAS/VAE the death of the patient is a moral evil; in allowing the patient to die one allows an ontic evil (the unintended death of the patient) for some higher good, such as preservation of dignity.[15 16]

People often state that morality cannot be as complicated as this analysis has made it. While I am as much a proponent of simplicity as anyone, two points undermine this simplicity rule. The sheer fact of complexity of this formulation does not mean that it is not adequate to determining moral culpability. The second point is best made with a question: whoever said the moral world is simple? The complexity of the formulation might be adequate to the messiness of the world. Moreover, this moral construction is not black and white as it is often characterised. It means there is a nuanced understanding of intention as related to an older understanding of causality.

I find another question more salient: why do people ask the simplicity question? I believe the answer is precisely because we are concerned with efficiency now that we have dispensed with formal and final causes, and it is this historical point that I am making. The direct-indirect distinction—that is to say, the VAE/PAS allowing to die distinction—no longer makes sense to our contemporary ears, for the distinction hinges in formal and final causal relations. With the embracing of solely efficient causality, there can be no action that transcends the consequences of the action. So with the rise of a modern metaphysics—a metaphysics of efficiency—we are left only with efficiency and effectiveness of actions—the two great moral principles of modernity, according to Alasdair MacIntyre.[17] It is from this efficiency metaphysical understanding that we see the rise of utilitarian and other consequentialist ethics. Only the effects of an action determine its morality, rather than the intentions of the actor. It is this point that flies in the face of both traditional moral and legal understandings of causing death; for in so far as one is a moral agent that can act in the world, it matters not in the least about the character or intentions of the actors—patient included—in PAS/VAE. Only the effects count in whatever calculus predominates at the time of the calculation, making traditional legal formulations, built upon the traditional moral formulations, completely obsolete when it comes to VAE/PAS. Now, I shall show that efficiency and effectiveness are at the heart of the drive to legalise VAE/PAS.

ON THE EFFICIENCY PARADIGM

In a morality older than contemporary medicine, one can distinguish between letting die—a morally acceptable practice—and VAE/PAS—traditionally morally equivalent and unacceptable. As stated, these practices have traditionally been distinguished along traditional philosophical categories of causality. The title question offered in an essay by Miller, Brody, and Quill is, however, very telling and is illustrative of my claim of the hegemony of efficiency and effectiveness in the course of the care of the dying: ''can physician assisted suicide be regulated effectively?''[18] In this essay, emphasis has shifted to the regulative function of the physician who can efficiently assure proper authorisation of death inducing activity. The key regulative function of the physician is to assure more effective responses to the patient's desires. The explicit request for death must be judged by the physician to be the patient's autonomous request for death. In short, the physician—or a physician—will serve as the procedural regulator of the social apparatus of taking a patient's life. The physician examines and regulates by interrogating the patient's motives and desires, assuring autonomy in a sea of heteronomous factors. The physician acts as an efficient cause in checking the patient's autonomy. Their conclusions are that with the proper social apparatus in place, physicians can efficiently manage the checking of a patient's autonomy.

Efficiency, however, extends beyond the social apparatus of death inducing activity to the killing action itself. In another essay, Quill *et al* provide a list of six approaches to a patient who is beyond the help of curative medical care and who opts for non-curative therapy; four of these practices have traditionally fallen within accepted medical practice and two fall outside accepted practice. I will briefly discuss the six practices to illustrate the efficiency point.

1. Standard pain management: the patient receives quality pain management, including care that may shorten his life, but for which the physician has not traditionally been thought culpable. This employs the rule of double effect.
2. Forgoing life sustaining therapy: the patient may choose not to undergo major curative interventions should he find them cumbersome. Physician involvement is necessary in so far as the physician must cease and desist. Time to death depends on the aggressiveness of the disease.
3. Voluntary Stopping of Eating and Drinking (VSED): the patient, of his own accord, chooses to stop eating and drinking. No physician involvement is really needed. This requires tremendous will power on the part of the patient and thus it is clear that the patient chooses this method of his own accord. Time to death is anywhere from one to three weeks and the lengthiness of time to death makes this option less than optimal because the patient's clarity of cognition may ''raise questions about whether the action remains voluntary'' (Quill *et al,*[13] p 2100). Quill *et al* see this practice as potentially problematic, on the one hand, because to continually offer food and drink may also undermine the patient's resolve to not eat or drink; on the other hand, if the palliative care team does not continue to offer food or water to the patient, the physician cannot continue to assure that the choice is autonomous. Moreover, the physician is not present (the patient is at home) to continue the regulative function, and thus ''palliation of symptoms may be inadequate, the decision to forgo eating and drinking may not be informed, and cases of treatable depression may be missed'' (Quill *et al,*[13] p 2100). While I agree that many of these issues are important, the point remains that in this assessment, the physician must be present to assure the efficiency of the process of dying.
4. Terminal Sedation (TS): in this instance, a continuous infusion of a medication, usually a benzodiazepine, is given in such quantities so as to induce complete sedation. The goal is to increase the infusion until such time as the patient appears to be comfortable. Quill *et al* suggest that with TS, the practitioners are in a better position to ensure that the decision is voluntary, given that the regulative aspects of most medical practices are extensive; assuring that the patient is repeatedly questioned about her desire to go forward with this intervention (Quill *et al,*[13] p 2100).
5. Physician assisted suicide (PAS): as stated, in this practice the physician writes a prescription for a large dose of barbiturates. These induce deep sleep and finally suppress respiration, inducing death. The patient is the main actor here, as the physician plays a more passive role (though Quill *et al* state that the physician plays an indirect role—a confusion of traditional moral terminology). In addition to violating some traditional medical mores, this practice is ''not always effective'', as stated by Quill *et al* and potentially messy, as it may induce vomiting (Quill *et al,*[13] p 2100). Without the physician present, the patient's family may lose heart and become scared, taking the patient to the emergency room where he may be resuscitated and receive unwanted therapeutic interventions.
6. Voluntary active euthanasia (VAE): in this practice, the physician is much more of an actor. After receiving a strong sedating agent, the patient receives a lethal dose of medication, usually a paralytic agent possibly followed by a bolus of potassium chloride to stop the heart. ''VAE has the advantages of being quick and effective'' (Quill *et al,*[13] p 2100). Physicians again can ensure the voluntary nature of the act right up to the time of death, thus fulfilling the regulative function for the social apparatus.

What is remarkable about this listing of practices is that the distinctions of traditional morality are gone. There is no mention of intention or the moral integrity of the physician. There is little mention of patient intention, and then only in terms of autonomy. The actions are only assessed in terms of the final effect: death. The moral distinctions are removed precisely because Quill *et al* have moved to a metaphysics of efficiency. On this schema, these practices are really a part of a continuum of comprehensive care directed to the same final effect, death (Quill *et al,*[13] p 2102).[19] The main concern of Quill *et al* is the efficiency and effectiveness with which this continuum of care can be implemented—both efficiency of the social apparatus and efficiency of the process of death inducing activity. One gets the sense that VAE is the most efficient and effective means of bringing one to the final effect of all causes in the cause/effect series. Death is that final effect, to be embraced more efficiently, more quickly. The effectiveness of death inducing activity takes centre stage and intentionality no longer matters at all.

THE SPIRITUAL DIMENSION, OR THE POSSIBILITY OF TRANSCENDENCE

I can now make my point with regard to the contemporary framing of VAE/PAS. I have claimed that we now think in terms of efficient and material causes and place these at the centre of our moral deliberation rather than formal and final causes. That is to say, we think in terms of cause and effect. With regard to death, we tend to think of death as the final effect in the series of causes and effects. In fact, I would claim that the only way for Quill *et al* to list the six practices listed above as part of a continuum is to see them all in terms of the final effect, namely death. Thus, we are left with a mechanism of cause and effect all moving efficiently toward death and the physician becomes part of the mechanism of bringing that about.

Yet, there are more sinister ramifications than the mere moral ramifications of the metaphysics of efficiency. If death is the final effect in the immanent series of causes and effects, it is difficult to see how human meaning can be introduced into dying. With VAE, the most efficient and effective means of implementing death, according to Quill *et al*, there can be no point to the experience of dying, no meaningfulness of the dying process. The physician becomes an instrumental or efficient cause of death. The point is just to arrive at death. Death dispensing actions in the metaphysics of efficiency have lost any sense of final causality; that is to say, neither the patient's nor the physician's sense of a *telos*, or purpose can escape the series of causes and effects, not to mention the meaning and significance of dying itself. In short, there can be no meaning to the action beyond its material effects.

With the traditional framework, the sense of final causality, of human purpose in the face of failing materiality and efficiency, gave rise to the spiritual dimension of all human endeavours, even the endeavour of living in and through one's death. This sense of finality, the possibility of finding purpose and meaning in the experience of dying itself—that is to say, the possibility of transcending the material and efficient conditions of possibility is permitted today. Better said, lip service is given to the possibility that meaning might be found in they dying process, while the efficiency of the machine itself

collapses the process into achieving the terminal status of death.

However, two questions remain. First, can a patient who chooses death find meaning and purpose in the choice? The answer is most certainly she can. People throughout history have offered their own lives as a means to bring about a higher purpose—a *telos*. But this question is not the important question for a society. The second and most important question for our purposes is whether a social apparatus designed to bring about the death—the final effect in the immanent series of causes and effects—of a patient can have purpose and meaning when, for the purposes of the social apparatus, the point is to arrive at death. Can such a social apparatus efficiently designed to induce death promote the possibility of transcendence? The point is that the social apparatus is fundamentally nihilistic; finality in this kind of social apparatus is not a human end or purpose or *telos*. Rather, it will promote a death as a terminus and not a *telos*.

In the face of a failing body, failing materiality, all that is left is transcendence. I am arguing that the efficiency paradigm runs the risk of rendering transcendence in human living and dying meaningless, for there is no transcending the conditions of life's material or efficient possibilities. By institutionalising the metaphysics of efficiency toward death, we frame all human dying, and thereby living, as impossible of meaning. That is why there is so much disgust with the increased technologisation of medicine. The efficient social apparatus for death induction will become just that, a further mechanisation of dying and therefore the further mechanisation of human living. And as argued above, the physician serves merely an instrumental role.

In short, I am saying that, by accepting mere efficiency in the physician's action, one is precluding something altogether more spiritual. One precludes that dimension often referred to as the therapeutic relationship. That is to say, sometimes healing occurs in empathically accompanying the patient through the most terrible of times. Or as Abraham Verghese recently stated of his care of patients in the early years of the HIV/AIDS epidemic: ''In finding that we had nothing to offer, we found that we had everything to offer''.[20] That everything he had to offer includes the human touch, the listening, the caring, and the staying the course in the face of tremendous discomfort for both patient and physician. But it was the lack of efficient tools that allowed those meaningful interactions. Nothing was left but empathy. And the world's religious traditions have always considered relationship as a means to transcend the tragedies of the world.

In the efficiency paradigm, the physician him or herself cannot really enter into a therapeutic relationship with the patient, for the instrumental efficiency model drives itself forward as the physician in his or her person is a mere mechanism bringing about material health in most instances, but also the final effect, death, in VAE/PAS. Yet, in a traditional formulation, when there is nothing mechanical or instrumental to offer, we have the most to offer our patients. Physicians and the healthcare team can create space for meaning to occur with friends and families. Or they can offer friendship, companionship, compassion—all of which might lead to healing even in the face of pain, suffering, and death. In embracing the metaphysics of efficiency, we render the possibility of healing in and through death impossible, because death is the final effect on the modern understanding. And in fact, for the proponents of the metaphysics of efficiency, this final statement will be impossible to understand.

Finally, I have prepared the ground to say what I want to say in the next essay, namely, that in framing our questions solely within the metaphysics of efficiency, many important features of human living and thriving—even living and thriving in death—slip beneath the threshold of our awareness. I am arguing that if we continue down the efficiency road through the institutionalisation of death inducing activity, we disallow human purpose in dying, but also in our living. It is to this task that I turn in the next essay.

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REFERENCES

1 **Minow M**. Which question? Which lie? Reflections on the physician assisted suicide cases. *Supreme Court Review* 1997:1–30.
2 **Aristotle**. *Physics book II, 3. The complete works of Aristotle*. Princeton, NJ: Princeton University Press, 1984:315–446.
3 **Burtt EA**. *The metaphysical foundations of modern physical science*. Amherst, NY: Humanity Books, 1999.
4 **Bacon F**. *The new organon*. Cambridge: Cambridge UP, 2000.
5 **Descartes R**. *Discourse on method* [trans Cress DA]. Indianapolis, IN: Hackett Publishing, 1980.
6 **Janssens, L**. Ontic evil and moral evil. In: Curran C, McCormick RA, eds. *Readings in moral theology: moral norms in the Catholic tradition, vol 1*. New York: Paulist Press, 1979:40–93.
7 **Aquinas T**. *Summa theologiae* [trans Hughes WD]. New York: McGraw-Hill, 1975, Ia–IIae, question 55, article 19, 9.
8 **Rachels J**. Active and passive use of euthanasia. *NEJM* 1975;**292**:78–80.
9 **Quill T**. The ambiguity of clinical intentions. *N Engl J Med* 1993;**329**:1039–40.
10 **Brody H**. Causing, intending, and assisting death. *J Clin Ethics* 1993;**4**:112–17.
11 **Sulmasy DP**, Pellegrino, EP. The rule of double effect: clearing up the double talk. *Arch Intern Med* 1999;**159**:545–50.
12 **Donagan A**. Moral absolutism and the double effect exception: reflections on Joseph Boyle's ''Who is entitled to double effect?'' *J Med Philos* 1991;**16**:495–509.
13 **Quill TE**, Lo B, Brock DW. Palliative options of last resort: comparison of voluntarily stopping eating and drinking, terminal sedation, physician assisted suicide, and voluntary active euthanasia. *JAMA* 1997;**278**:2099–104.
14 **Alpers A**, Lo B. Does it make clinical sense to equate terminally ill patients who require life sustaining interventions with those who do not? *JAMA* 1997;**277**:1705–8.
15 **Di Ianni A**. The direct/indirect distinction in morals. In: Curran C, McCormick RA, eds. *Readings in moral theology: moral norms in the Catholic tradition, vol 1*. New York: Paulist Press, 1979:41.
16 **Wildes K**. Ordinary and extraordinary means and the quality of life. *Theological Studies* 1996;**57**:500–12.
17 **MacIntyre A**. *After virtue: a study of moral theory*. Notre Dame, IN: Notre Dame Press, 1984.
18 **Miller FG**, Brody H, Quill TE. Can physician assisted suicide be regulated effectively? *J Law Med Ethics* 1996;**24**:225–32.
19 **Quill TE**, Coombs Lee B, Nunn S for the University of Pennsylvania Center for Bioethics Assisted Suicide Consensus Panel. Palliative treatments of last resort: choosing the least harmful alternative. *Ann Intern Med* 2000;**132**:488–93.
20 **Verghese A**. *The pen and the stethoscope*, Public address to the Association of Medical Humanities. 2005 Jul 12; Truro, Cornwall, UK.